MISSOURI DEPARTMENT OF HEALTH
BUREAU OF FAMILY HEALTH

CLAIM FOR STATE PAYMENT OF MEDICAL EXAMINATION CHARGES

FORM 3

PLEASE TYPE OR PRINT

The following charges are made in connection with the medical examination of:

HOSPITAL ADMISSION NUMBER OF VICTIM	
DATE OF EXAMINATION	LOCATION OF EXAMINATION AND COUNTY

ITEMIZE REASONABLE HOSPITAL AND PHYSICIAN CHARGES:

	TOTAL	**$**

An itemized hospital/physician bill must be attached to this form.

Claim is hereby made for payment of these total charges. To the best of our knowledge the patient does not have insurance nor Medicare or Medicaid that would cover this medical examination. The patient will not be billed for these charges.

A report of this medical examination has been made to the Prosecuting Attorney for the following county.

COUNTY WHERE INCIDENT OCCURRED	
DATE FORMS COMPLETED	ADDRESS OF HOSPITAL
SIGNATURE OF PERSON COMPLETING THESE FORMS ►	TELEPHONE NUMBER OF HOSPITAL
NAME OF PERSON COMPLETING THESE FORMS	TITLE OF PERSON COMPLETING THESE FORMS